Clinical practice guidelines for surveillance colonoscopy:
Dissemination Plan

1. BACKGROUND

Colorectal cancer (CRC) is Australia’s second commonest internal malignancy. Although age-standardised incidence and mortality rates are falling in this country, CRC still kills more Australians than any other cancer apart from lung cancer. This is despite the window of opportunity offered by CRC biology.

The polyp-cancer sequence means that, with rare exceptions, appropriately timed colonoscopy, by detecting and completely removing all conventional and serrated adenomas, could dramatically reduce both CRC incidence and mortality. To maximize this potential benefit, colonoscopy needs to be performed to very high standards and it needs to be performed at appropriate intervals. The revised guideline focus on the appropriate use of colonoscopy in colorectal cancer (CRC) prevention.

These draft clinical practice guidelines are a revision and update of the 2011 Clinical practice guidelines for Surveillance Colonoscopy. They were originally developed in 2010, and since then, have been widely used as a reference and referred to by colonoscopists, including general practitioners (GPs) and specialists to guide clinical practice.

This current revision and update was commissioned and funded by the Department of Health Commonwealth of Australia.

The guidelines include relevant practice points and recommendations for health professionals based on a systematic review of the evidence.

The revised guidelines will be developed and published as online guidelines on the Cancer Council Australia wiki platform. The online version of the guideline provides maximum transparency to all stakeholders as it offers access to all background documents (literature searches, literature assessments, recommendation development, public consultation results), so guideline users can get detailed access to the evidence base and rationale that underpins each recommendations.

2. SCOPE OF THE PROJECT

The aim of this project was to revise the Clinical practice guidelines for Colonoscopy Surveillance (2011) according to the procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines and gain NHMRC approval. The guideline development has been conducted on Cancer Council Australia’s custom-built wiki platform* for guideline development.

* The wiki platform supports all stages of guideline development, ie. recording literature searches, conducting the systematic reviews, support internal review and public consultation and providing real-time background documentation and has been proven to be more effective and transparent compared to systems, such as Reference Manager, Word, Excel, Outlook, that we used to develop previous guidelines.
The developed guidelines, through their application in practice, will maximise best practice in colonoscopy surveillance. They address three main questions:

- when to repeat colonoscopy after adenomatous polypectomy?
- when to repeat colonoscopy after curative resection of colorectal cancer?
- when to perform colonoscopy in those patients with inflammatory bowel disease who have an increased risk of developing CRC?

3. AIM AND SCOPE OF THE DISSEMINATION PLAN

The aim of this dissemination plan is to outline the ways in which Cancer Council Australia will promote and distribute the approved guideline. The outcome is to ensure all relevant health professionals have access to the guidelines. This will in turn promote best practice in their health service delivery to their patients.

4. METHODOLOGY

Cancer Council Australia has developed a multi-strategy approach for the dissemination of the guidelines, as this has been shown to positively influence guideline uptake.\(^1,2\) The multidisciplinary working party overseeing the guideline will be consulted with regarding the dissemination plan.

The guidelines will be made available as online guidelines via the Cancer Council Australia Clinical Guidelines Wiki, making them a web-based global resource. The online guideline version increases availability as well as accessibility. Usage will be tracked and analysed with a web analytics solution.

Interlinking and listing the guidelines on national and international guideline portals is an important part of the digital dissemination strategy. Credible Australian health websites will be approached to link to the online guidelines. For example, eviQ – an internationally recognised online resource that provides evidence-based cancer treatment information to help health professionals identify the best course of cancer treatment and care for their patient’s needs\(^3\) and healthdirect Australia – an Internet gateway designed to help individuals find reliable, high quality Australian health information.\(^4\)

a. Target Audiences

Cancer Council Australia recognise the following target audiences:

- Internal stakeholders (State Managers, Support Group and Outreach Coordinators, Chapter Councillors, Ambassadors, State and Territory Cancer Councils)
- External stakeholders (health care professionals, peak body cancer organisations, community sector organisations, cancer treatment centres, Government and the general community)
- Consumer audiences (general population, people at high risk, people affected by colorectal cancer, including specific target population groups such as people from culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander communities, and partners and carers of people with colorectal cancer)

b. Dissemination Activities

Cancer Council Australia will utilise a variety of media, avenues and pathways to promote and disseminate information to the target audiences.
**Soft Launch**

When promoting and disseminating information on newly developed guidelines, Cancer Council Australia will conduct ‘soft launches’.

The guidelines will be launched via an email alert to professional organisations, interested groups and clinical experts in the field, directing them via a URL link to the wiki guidelines. In addition, the final guidelines will be launched with a media release to relevant contacts, promoting the guidelines and key recommendations.

To promote the availability of guidelines, ongoing activities may be conducted through print and social media campaigns as well as disseminating the guidelines through further meetings and national and international conferences.

**Conferences**

Formal professional forums will be utilised as avenues through which the guidelines are disseminated. Conferences will provide a forum to promote the availability of the guidelines. The following conferences may be attended in 2019 to promote the availability and dissemination of guidelines and resources once completed:

<table>
<thead>
<tr>
<th>Conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterological Society of Australia (GESA) Australian Gastroenterology Week (AGW)</td>
</tr>
<tr>
<td>Royal Australian College of General Practitioners (RACGP)</td>
</tr>
<tr>
<td>Colorectal Surgical Society of Australia and New Zealand (Combined ANZ Colorectal Surgical Meeting)</td>
</tr>
<tr>
<td>Clinical Oncology Society of Australia (COSA) Conference</td>
</tr>
<tr>
<td>Cancer Nurses Society of Australia (CNSA) Conference</td>
</tr>
<tr>
<td>Medical Oncology Group of Australia (MOGA)</td>
</tr>
</tbody>
</table>

Where appropriate, Cancer Council Australia will also integrate dissemination activities pertaining to the guidelines into their existing promotional activity planning around organisational events, forums and conferences.

**Publications**

The guidelines may be promoted through publications such as Cancer Forum. Research activities pertaining to the development of the guidelines may be written up as manuscripts for either submission to peer-reviewed journals for publication or as monograph publications.

**External promotion channels**

The guidelines will also be promoted using external promotion channels/mediums. Professional colleges and other organisations will be encouraged to promote the availability of the guidelines through their websites and resources such as newsletters.

Additionally, the guidelines will be listed on national and international guideline portals such as the NHMRC Clinical Practice Guideline portal and Guidelines International Network (GIN) guidelines library.
5. KEY RECOMMENDATIONS FOR PRACTICE WHICH FORM CONTENT FOR MATERIAL FOR DISSEMINATION

The following table is a summary of the key clinical practice guideline recommendations arising from this project that are most likely to lead to improvements in health outcomes, for consideration in implementation.

See Appendix 1 for a list of the clinical questions and abbreviations/codes.

In the table below, EBR = Evidence-based recommendation; CBR = Consensus-based recommendation; PP = Practice point. Please see the NHMRC approved recommendation types and definitions (Source: National Health and Medical Research Council. Procedures and requirements for meeting the NHMRC standard for clinical practice guidelines. Melbourne: National Health and Medical Research Council, 2011).

4 Healthdirect Australia. www.healthdirect.gov.au
## Key Recommendations

<table>
<thead>
<tr>
<th>High-quality bowel preparation is a crucial pre-requisite for successful colonoscopy. Optimal preparation is achieved with split-dose or same-day preparation timing.</th>
<th>Type (and grade, if applicable)</th>
<th>Relevant PICO question code, if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>

| Fundamental colonoscopic inspection technique should ensure systematic exposure of the proximal sides of folds and flexures, intensive intraprocedural cleansing and adequate distension of the colon. | PP | n/a |

| Colonoscopists should undergo training in the fundamentals of mucosal exposure and inspection techniques, and in the endoscopic appearance of adenomas and serrated lesions to increase detection rates and improve clinical outcomes of colonoscopy. | PP | n/a |

| A second examination of the proximal colon in either the forward view or in retroflexion is recommended to improve lesion detection, particularly in patients with an expected higher prevalence of neoplasia. | PP | n/a |

| Sessile polyps under 10mm in size should be removed using cold snare polypectomy. Hot biopsy forceps should not be used because they are associated with unacceptably high rates of incomplete resection and deep mural injury. | PP | n/a |

| Colonoscopy should be performed only for accepted indications, which should be clearly documented. | PP | n/a |

| Individual proceduralists should routinely document and maintain their adenoma detection rate at >25% in patients over the age of 50-years and without a diagnosis of inflammatory bowel disease. | PP | n/a |

| Serrated polyp detection rates are likely to be an equally valid marker of quality as adenoma detection rate, and increasing evidence suggests that maintaining a rate of >10% in patients over age 50 years without a diagnosis of inflammatory bowel disease may be a suitable indicator. | PP | n/a |

| All colonoscopists should have their training certified by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy and undergo regular recertification through an endorsed program | PP | n/a |

| Endoscopists and pathologists need to be aware of serrated polyps and be able to recognise and endoscopically manage them. | PP | |

| Low-risk individuals – conventional adenomas only |
|---|---|
| First surveillance intervals should be no sooner than 5 years following the complete removal of low-risk conventional adenomas only (1–2 small [<10mm] tubular adenomas without high-grade dysplasia). | EBR | SAD1 |

| Consistently high-quality colonoscopy is imperative for optimal cost effectiveness and for implementation of uniform surveillance guidelines. | PP | SAD1 |
Surveillance intervals should be determined after the colon has been cleared of all significant neoplasia, once histology is known and in the context of individualised assessment of benefit to the patient.

A shorter surveillance interval of 5 years could be considered for men who fit the criteria for the metabolic syndrome, because they may have increased risk of metachronous advanced neoplasia following removal of low-risk adenomas.

Return to the National Bowel Cancer Screening Program with a faecal occult blood test after 4 years, is an appropriate option and should be discussed with the patient.

Individuals with a significant family history of colorectal cancer should be assessed according to current Australian clinical practice guidelines for the prevention, early detection and management of colorectal cancer (see Risk and screening based on family history) in addition to these recommendations, and the shorter interval used.

### High-risk individuals – conventional adenomas only

First surveillance intervals following removal of high-risk conventional adenomas only should be stratified according to the type and number of high-risk features (size $\geq 10$ mm, high-grade dysplasia (HGD), villosity, 3–4 adenomas):

A surveillance interval of 5 years is recommended for patients with either of the following:

- 1–2 tubular adenomas with HGD or tubulovillous or villous adenomas (with or without HGD), all of which are $< 10$ mm
- 3–4 tubular adenomas without HGD, all of which are $< 10$ mm

A surveillance interval of 3 years is recommended for patients with any of the following:

- 1–2 tubular adenomas with HGD or tubulovillous or villous adenomas (with or without HGD), where the size of one or both is $\geq 10$ mm
- 3–4 tubular adenomas, where the size of one or more is $\geq 10$ mm
- 3–4 tubulovillous and/or villous adenomas and/or HGD, all $< 10$ mm

### Clinically significant serrated polyps only

5 years for:

- 1–2 sessile serrated adenomas all $< 10$ mm without dysplasia

3 years for:

- 3–4 sessile serrated adenomas, all $< 10$ mm without dysplasia
- 1–2 sessile serrated adenomas $\geq 10$ mm or with dysplasia, or hyperplastic polyp $\geq 10$ mm
- 1–2 traditional serrated adenomas, any size.
1 year for:
- ≥5 sessile serrated adenomas <10mm without dysplasia
- 3–4 sessile serrated adenomas, one or more ≥10mm or with dysplasia
- 3–4 traditional serrated adenomas, any size.

**Clinically significant serrated polyps and synchronous conventional adenomas**

5 years for:
- 2 in total, sessile serrated adenoma <10mm without dysplasia.

3 years for:
- 3–9 in total, all sessile serrated adenomas <10mm without dysplasia
- 2–4 in total, any serrated polyp ≥10mm and/or dysplasia
- 2–4 in total, any traditional serrated adenoma

1 year for:
- ≥10 in total, all sessile serrated adenomas <10mm without dysplasia
- ≥5 in total, any serrated polyp ≥10mm and/or dysplasia
- ≥5 in total, any traditional serrated adenoma

**Synchronous high-risk conventional adenoma (tubulovillous or villous adenoma, with or without HGD and with or without size ≥10mm)**

3 years for:
- 2 in total, sessile serrated adenoma <10mm, without dysplasia
- 2 in total, serrated polyp ≥10mm and/or dysplasia
- 2 in total, any traditional serrated adenoma

1 year for:
- ≥3 total adenomas, sessile serrated adenoma any size with or without dysplasia
- ≥3 total adenomas, one or more traditional serrated adenoma

<table>
<thead>
<tr>
<th>High-quality reporting from endoscopists and pathologists is required to allow accurate risk stratification for surveillance interval recommendations.</th>
<th>PP</th>
<th>SAD4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The findings of the previous two colonoscopies predict high-risk findings on the subsequent colonoscopy and should be considered when recommending subsequent surveillance intervals.</td>
<td>PP</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Colonoscopy should be performed 3–6 months after resection for patients with obstructive colorectal cancer in whom a complete perioperative colonoscopy could not be performed and in whom there is residual colon proximal to the location of the pre-operatively obstructing cancer.

<table>
<thead>
<tr>
<th>EBR (C)</th>
<th>COL1</th>
</tr>
</thead>
</table>

Other clinically high-risk patients should be considered for more frequent surveillance colonoscopy after surgery than would otherwise be recommended (e.g. initial post-operative colonoscopy at 1 year and then 1–3 yearly depending on personalised estimate of risk). These include patients:
- whose initial diagnosis was made younger than 40 years of age,
- with suspected but un-identified hereditary colorectal cancer syndromes
- with multiple synchronous cancers or advanced adenomas at initial diagnosis.

| PP | n/a |

Surveillance colonoscopy should commence after 8 years of onset of inflammatory bowel disease symptoms in those with at least left-sided ulcerative colitis or Crohn’s colitis with involvement of at least one third of the colon.

| EBR (C) | SUR1 |

Patients with IBD at high risk of CRC (those with PSC, ongoing chronic active inflammation, prior colorectal dysplasia, evidence of intestinal damage with colonic stricture, pseudopolyps or foreshortened tubular colon or family history of CRC at age ≤50 years) should undergo yearly surveillance colonoscopy.

| CBR | SUR2 |

Patients with IBD at low risk of CRC (those with quiescent disease and no other risk factors, and with inactive disease on consecutive surveillance colonoscopies) may undergo surveillance colonoscopy every 5 years.

| CBR | SUR2 |

IBD surveillance requires high-quality colonoscopy:
- performing the colonoscopy when the patient is in clinical and endoscopic remission
- excellent bowel preparation
- the use of high-definition colonoscopes
- ensuring optimal and full visualisation of the mucosal surface during slow withdrawal.

| PP | SUR3 |

When determining an individual’s appropriate surveillance frequency, the risk factors for progression of low-grade dysplasia (LGD) towards high-grade dysplasia (HGD) or colorectal cancer are: older age at diagnosis of LGD (age >55 years), male sex and inflammatory bowel disease duration of >8 years at diagnosis of LGD.
Appendix 1. List of clinical questions and codes

Colonoscopic surveillance after polypectomy

SAD1: What should be the surveillance colonoscopy for patients are low risk (1-2 small <10mm tubular adenomas)?

SAD2: What should be the surveillance colonoscopy for patients at high risk (size ≥10mm, HGD, villosity and/or 3-4 adenomas)?

SAD3: What is the appropriate colonoscopic surveillance after the removal of large sessile or laterally spreading adenomas?

SAD4: What is the appropriate colonoscopic surveillance after the identification of sessile serrated adenomas and traditional serrated adenomas?

SAD5: What should be the surveillance colonoscopy for patients with adenoma multiplicity?

SFH1: Is the surveillance colonoscopy recommendation different for patients with adenomas who also have a family history of CRC?

The role of surveillance colonoscopy after curative resection for colorectal cancer

COL1: What is the role of pre or peri-operative colonoscopy in CRC patients?

FUC1: At what time points after CRC resection should surveillance colonoscopy be performed?

Colonoscopic surveillance and management of dysplasia in inflammatory bowel disease (IBD)

SUR1: What is the appropriate time to commence surveillance in IBD patients (ulcerative colitis and Crohn’s patients, and effects of primary sclerosing cholangitis or family history of CRC)?

SUR2: What is the most appropriate time interval for surveillance in IBD patients based on risk?

SUR3: What is the recommended surveillance strategies for surveillance in IBD patients?

MNG1: What should be the protocol to manage elevated dysplasia in IBD?
MNG2: What should be the protocol to manage high grade dysplasia in IBD?

MNG3: What should be the protocol to manage low grade dysplasia in IBD?

MNG4: What should be the protocol to manage indefinite dysplasia in IBD?